

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 50M 4/83  
(VRA 15, 4)

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										84 19376	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIVIA K. BANKS					2a. DATE OF DEATH MONTH DAY YEAR 07-03-84			2b. HOUR 3:05 P M			
3 SEX F		4 RACE NEG		5. DATE OF BIRTH MONTH DAY YEAR 01 04 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. STATE MD.			13b. COUNTY DORCHESTER		13c. CITY OR TOWN TRAPPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST IRA - KEMP			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLAUDIA - SCOTT			13e. STREET ADDRESS / ZIP CODE RT. Box 263 21673					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 577-20-1217		17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of Endometrium. DUE TO, OR AS A CONSEQUENCE OF (b) Cereberia DUE TO, OR AS A CONSEQUENCE OF (c) Anemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. - MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/27 19 84, to 7/3 19 84, that (I) (we) lost saw the deceased alive on 7/3 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Vinodrai Mehta					DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/3/84.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINODRAI MEHTA					22e. ADDRESS 400 AURORA ST. Cambridge Md 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/7/84		23c. NAME OF CEMETERY OR CREMATORY Paradise Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Trappe TA Md				
24. FUNERAL DIRECTOR NAME George Lashell					ADDRESS Easton Md		25a. DATE REC'D. BY REGISTRAR JUL 9 1984				
					25b. REGISTRAR'S SIGNATURE Julia Burden						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 19377	
1. DECEASED NAME (TYPE OR PRINT) Clara V Bradshaw					2a. DATE OF DEATH MONTH DAY YEAR 7 16 84			2b. HOUR 5:30 PM			
3. SEX F		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 10 15 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired			12b. KIND OF BUSINESS OR INDUSTRY sewing mach. oper		
13a. STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Rhodesdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 221 21659			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel E Phillips				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara R Mills				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 57-12-8982				17. INFORMANT Jeanette Hughes				ADDRESS P.O. Box 172 Vienna Md. 21869			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe malnutrition DUE TO, OR AS A CONSEQUENCE OF (b) Reflux esophagitis - ? aspiration DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes + pernicious Anemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 77 to 7-16-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If warranted) (did not) view the body after death.											
22b. SIGNATURE AR WILKE				DEGREE				22c. DATE SIGNED 7-18-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 400 Maryland Ave 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/18/84		23c. NAME OF CEMETERY OR CREMATORY E. NEW MARKET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE DOR. MD.					
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					8 4 1 9 3 7 8				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
PAUL CLARENCE BRAKE					7 10 84 8:40 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
male		white		07 04 1906		78		8:40 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		U.S.A.				Dorchester MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Cambridge House				timberman		logging	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS?				
13a. STATE					13b. COUNTY				
Md.					Dor.				
13c. CITY OR TOWN					13d. STREET ADDRESS				
Cambridge					205 Belvedere Ave. 21613				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Hamilton Jackson Brake					Alice Crislip				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					220-12-1360				
17. INFORMANT					ADDRESS				
Eloise A. Brake					Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ORGANIC BRAIN SYNDROME									2 years
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									years
(b) ATHEROSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/15, 1984, to 7/10, 1984, that (I) (we) lost saw the deceased alive on 7/10, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Michael A. Moskewicz MD.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
MICHAEL A. MOSKEWICZ MD.						503 BYRN ST CAMBRIDGE MD. 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
cremation		7/14/84		Delmarva Crematory		Lewes		Sussex Del.	
24. FUNERAL DIRECTOR									
John T. Brown 700 Locust St. Cambridge, MA 02142									
JUL 16 1984 John Davidson-Randall									



100% COTTON FIBER

CHIFFON



Investigation Division, Federal Bureau of Investigation, U.S. Department of Justice

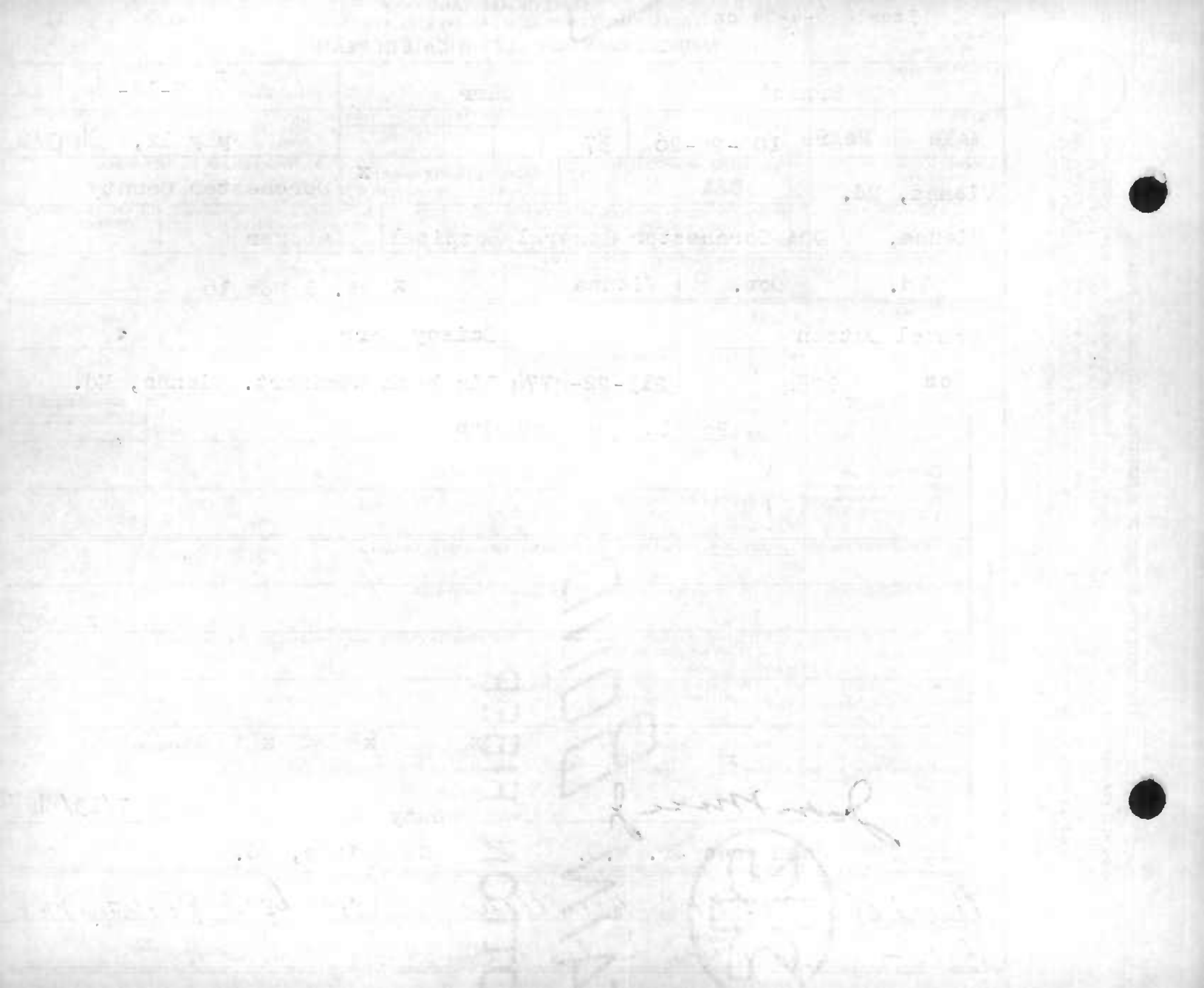




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 798  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19380	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Ernest Carr										2a. DATE KNOWN OF DEATH 7-12-84	
3. SEX Male										7b. HOUR AM	
4. RACE Negro										7c. DATE PRONOUNCED DEAD July 12, 1984	
5. DATE OF BIRTH MONTH DAY YEAR 10-28-26										7d. HOUR 3AM	
6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna, Md.											
7b. CITIZEN OF WHAT COUNTRY? USA											
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.	
10. CITY OR TOWN OF DEATH Vienna, DOA										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital										12b. KIND OF BUSINESS OR INDUSTRY	
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.										13b. COUNTY Dor.	
13c. CITY OR TOWN Vienna										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS Rt. 1 Box 16 21869											
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Dutton										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisey Carr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. 213-22-4774	
16c. (IF YES, GIVE WAR OR DATES) 1954										17. INFORMANT ADDRESS Lizabeth Stewaert. Vienna, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occluding</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Mace Jr.</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 7/13/84	
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D. ADDRESS Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 7-14-84	
23c. NAME OF CEMETERY OR CREMATORY Bullish										23d. LOCATION CITY OR TOWN County STATE Harlock Dorchester Md	
24. FUNERAL DIRECTOR NAME West Funeral Home ADDRESS Salis. Md.										25a. DATE REC'D. BY REGISTRAR 7/17/84	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall											



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Emily Louise Collins</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>84</b>		2b. HOUR <b>1:30 A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>5</b> YEAR <b>1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS <b>73</b> DAYS <b>0</b> HOURS <b>0</b> MIN.
7. BIRTHPLACE (COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cambridge House</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Caroline</b>	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13d. STREET ADDRESS <b>21632 American Corner, Fed., Md.</b>	
14. FATHER'S NAME FIRST <b>Elmer</b> MIDDLE <b>Brown</b> LAST <b>Brown</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b> MIDDLE <b>Towers</b> LAST <b>Towers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-34-7560D</b>		17. INFORMANT ADDRESS <b>Md. 21632 Doris Fishell RD #2 Box 308 Fed.,</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hemangiosarcoma of right chest wall</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-27-84</b> to <b>7-27-84</b> , that (I) (we) last saw the deceased alive on <b>not seen alive</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Edmund T MacLaughlin</b>				22c. DATE SIGNED <b>7/27/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edmund T MacLaughlin</b>				22e. ADDRESS <b>10 Aurora St Cambridge, Md 21613</b>	
23a. BURIAL, CREMATION, REMOVAL SPECIES <b>Burial</b>		23b. DATE <b>7-29-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>	
24. FUNERAL DIRECTOR NAME <b>Harold W. Weaver - Federalburg, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>31</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

BP

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Receiving from  
the management of right about 10 months

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR AT 5 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Randall Dorsey Dayton		2a. DATE KNOWN OF DEATH ESTIMATED 7-23-84		2b. HOUR A.M.	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 05 10 1911	6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD July 23, 1984
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural rt. 2, Box 51		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman-city, retired	
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer C. Dayton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna May Willey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 214-07-9026		17. INFORMANT Ottillie H. Dayton		ADDRESS Item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few mons.</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John Mace Jr. M.D.		TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 7/25/84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/25/84		23c. NAME OF CEMETERY OR CREMATORY E. NEW MARKET CEM.	
23d. LOCATION CITY OR TOWN E. NEW MARKET		COUNTY DOR.		STATE MD.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR AUG 01 1984	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 9 3 8 3	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT) <b>Carl E. Dunnock, JR.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 17 1984</b>		2b. HOUR <b>12:30am</b>	
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 24 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>124 Willis St.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Grocer, retail</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Dor.</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>124 Willis St. 21613</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Emmett Dunnock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della Stokes</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT <b>Dorothy T. Dunnock</b>				ADDRESS <b>Item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>of rectum</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION <b>March 1982</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA rectum</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>82</b> , to <b>July 17</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>July 15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lewis M. Burnett</b> MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>July 17, 1984</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis M. Burnett</b>						22e. ADDRESS <b>4 Annapolis St Cambridge Md 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>7/19/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>						ADDRESS <b>CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 23 1984 John Davidson-Randall</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	4	1	9	3	8	4		
1- FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>NORMA BRYAN Frey</b>										2a. DATE OF DEATH MONTH <b>7</b> DAY <b>30</b> YEAR <b>84</b>				2b. HOUR <b>1 pm</b>				
3. SEX <b>female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH MONTH <b>10</b> DAY <b>02</b> YEAR <b>1888</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.									
10. CITY OR TOWN OF DEATH <b>Cambridge</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cambridge House</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>520 Glenburn Ave. 21613</b>									
14. FATHER'S NAME FIRST <b>Sewell</b> MIDDLE <b>Milbourn</b> LAST <b>Moore</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b></b> LAST <b>Norman</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>								
16b. SOCIAL SECURITY NO. <b>220-44-9675</b>					17. INFORMANT <b>Sewell A. Frey</b>							19. ADDRESS <b>19 Algonquin Rd. Cambridge Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Cerebral Hemorrhage)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>																		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 12 P.M. 19 84</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>7/12/84</b> , 19 <b>84</b> , to <b>7/30/84</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>7/30/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>Lawrence Maynard</b>										DEGREE <b>MD</b>				22c. DATE SIGNED <b>7/30/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>8/1/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>								
24. FUNERAL DIRECTOR NAME <b>Antonia 700 Forest St. Cambridge, Md 21613</b>										25a. DATE REC'D. BY REGISTRAR <b>AUG 3 1984</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendall</b>				

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20% GEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 3 8 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mazeline G. Hamilton			2a. DATE OF DEATH MONTH DAY YEAR 7-28-84			2b. HOUR 15 M		
3. SEX Female		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 8 29 09		6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		
12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MD			13b. COUNTY DORCH		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MENINGITIS DUE TO, OR AS A CONSEQUENCE OF (b) PROGRESSIVE DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE DECUBITUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 1 year								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE, SEPSIS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/28 1984 to 7/28 1984, that (I) (we) lost saw the deceased alive on 7/28 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE Hubert J. Feary MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/28/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/2/84		23c. NAME OF CEMETERY OR CREMATORY Waugh		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home				ADDRESS Salisbury Md.		25a. DATE REC'D. BY REGISTRAR AUG 6 1984		
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Patient may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 4 1 9 3 8 0	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Georgia V. Harper</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>7 31 84</i>					2b. HOUR <i>7:30</i> M	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>06 06 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.					
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>			13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>520 Glenburn Ave. 21613</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Dixon</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Willey</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			
16b. SOCIAL SECURITY NO. <i>212-74-4082</i>				17. INFORMANT <i>Mae Brown</i>				ADDRESS <i>Rt 1 Box 62 B Cambridge Md. 21613</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs.</i> <i>5 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>5/1/79</i> , 19____, to <i>7/3/84</i> , 19____, that (I) (we) last saw the deceased alive on <i>7/1/84</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Lawrence Maryann MD</i>					DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/3/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Maryann MD</i>					22e. ADDRESS <i>610 Race St Cambridge, Md 21613</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>8/2/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Churchyard Golden Hill</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dor. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John Thomas</i>					ADDRESS <i>700 East K - Cambridge, Md 21613</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 3 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Thomas</i>	

MEDICAL CERTIFICATION

25% CO<sub>2</sub>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Franklin Sewall Hurley, Jr.								7-10-84		19		84		6.3		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	White	5 19 18		66 YRS.						7/10/84		19		84		6.50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA		WIDOWED		DIVORCED		Dorchester County								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge		Dorchester General Hospital		Laborer		Farming											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Dorchester		Cambridge		YES <input type="checkbox"/> NO <input type="checkbox"/>		21613 131 Washington Street									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Franklin Sewall Hurley, Sr.						Della Mae Murphy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WWII				Patrick L. Hurley, Preston, MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Coronary occlusion													
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET													
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
John Mace Jr.		M.D. Deputy		7/12/84													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John Mace Jr.		Cambridge, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		7-13-84		St. Paul's Cemetery		Vienna, Dorchester, MD											
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Zeller Funeral Home, East New Market				MD JUL 26 1984													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

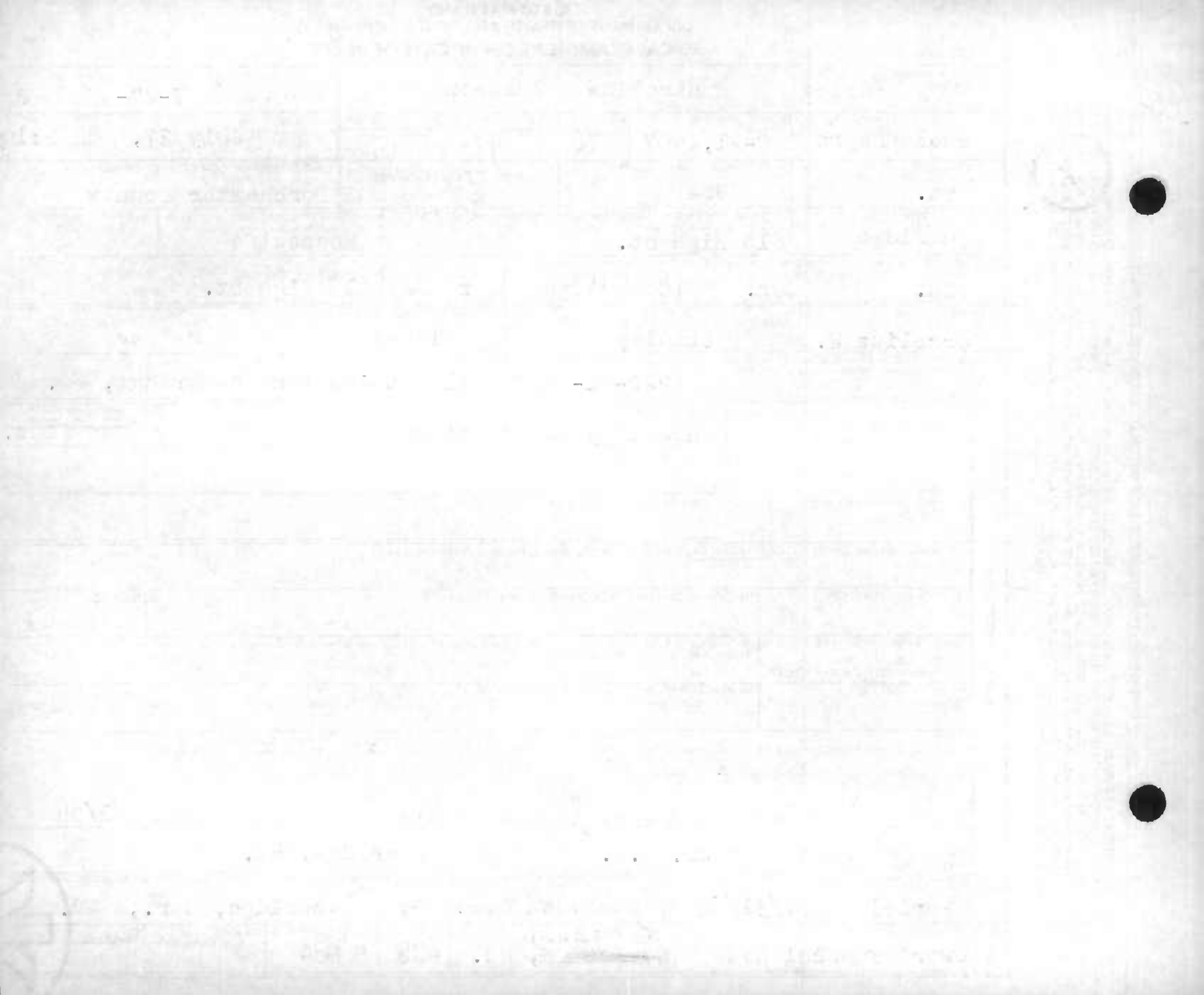
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Grace</b>			2a. DATE KNOWN OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>1984</b>			2b. HOUR <b>P.M.</b>		
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>21</b> YEAR <b>1907</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>76</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7c. DATE PRONOUNCED DEAD MONTH <b>7</b> DAY <b>27</b> YEAR <b>1984</b>		7d. HOUR <b>2:10 P.M.</b>
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>618 High St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>618 High st.</b> <b>21613</b>			
14. FATHER'S NAME FIRST <b>Cornelius H.</b> MIDDLE <b>Stanley</b> LAST <b>Stanley</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elnora</b> MIDDLE <b>Camper</b> LAST <b>Camper</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-01-8932</b>		17. INFORMANT ADDRESS <b>Wilbert Jackson Cambridge, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few Mins.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John Mace Jr.</b>		TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER					DATE SIGNED <b>8/1/84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>		ADDRESS <b>Cambridge, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/31/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bucktown Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Cambridge, Dor.,</b> COUNTY <b>Md.</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home</b> ADDRESS <b>Salisbury, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>		



Item 13a,b,c,e per Form 7/30/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ryan Purnell Jones</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 9 1984</b>			2b. HOUR A M <b>1:50</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 9 1984</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>-</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN <b>1 16</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester County</b> MD				
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Dor</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Rural 21613</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bruce Lenard Jones</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stephanie I. Camper</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT ADDRESS <b>Stephanie I. Camper P. O. Box 397 Hurlock, MD 21643</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrapartum Asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ecology, undetermined</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>July 9</b> , 19 <b>84</b> , to <b>July 9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>July 9</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <b>Jose M. deLeon</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/11/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jose M. deLeon, MD</b>			22e. ADDRESS <b>505 Byrn Street, Cambridge, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-12-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Eastern Shore Vet</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beulah, Dorchester, MD</b>			
24. FUNERAL DIRECTOR <b>Zeller Funeral Home, East New Market, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>				

MEDICAL CERTIFICATION

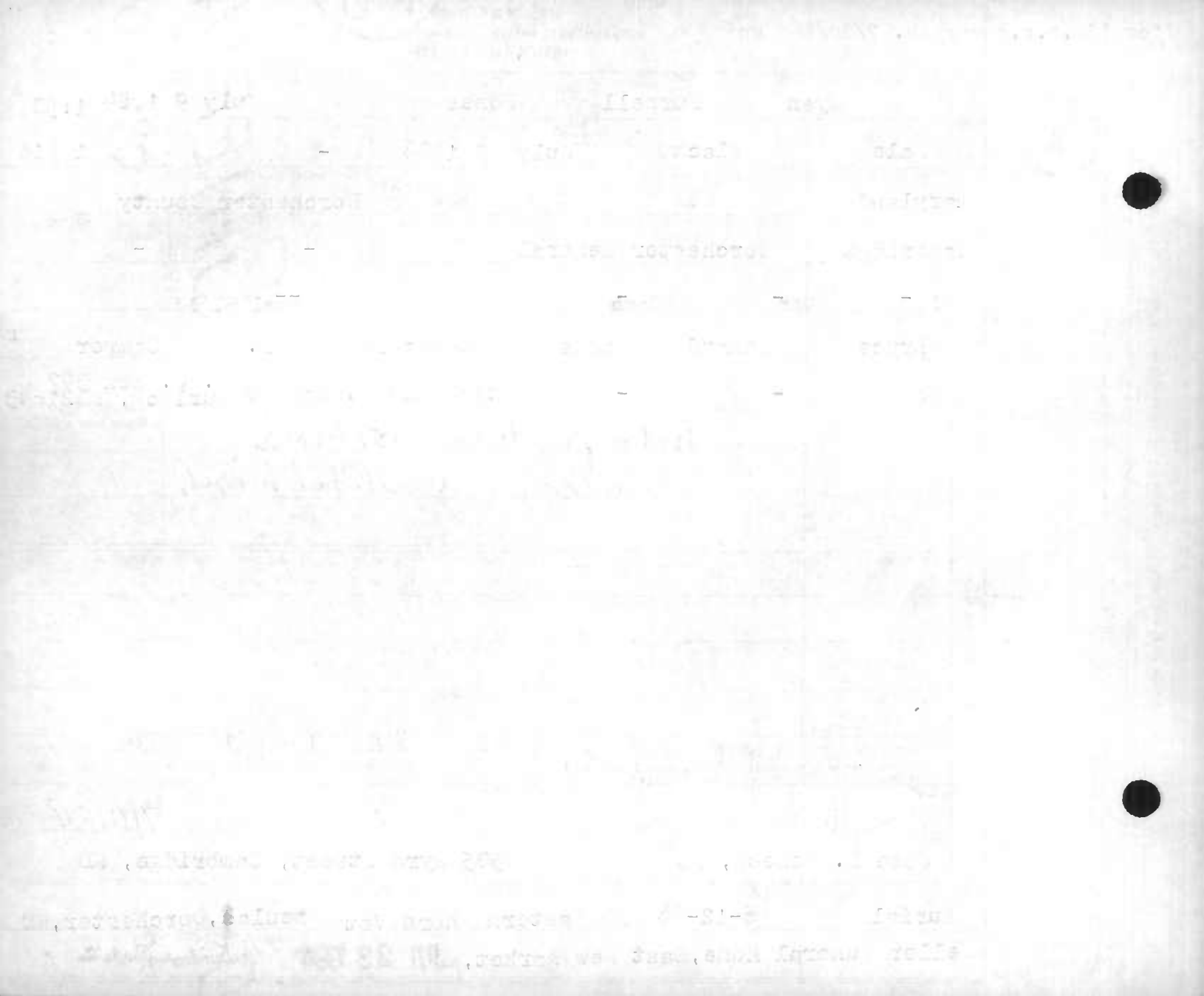
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 3 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ashley HUGH Lewis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 20 84</b>			2b. HOUR <b>9:54 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 3 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>insurance agent</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>East New Market</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt #1 Box 1334 E.N. Mkt. Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Ashley Lewis</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Inez Johnson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>214-10-0525</b>		17. INFORMANT ADDRESS <b>Oakey T. Lewis Item # 13</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **End Stage Ischemic**

DUE TO, OR AS A CONSEQUENCE OF:

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**3 days****General**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr Shariff</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr Shariff</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>7/22/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>E. NEW MARKET CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. NEW MARKET DOR. MD.</b>
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24. FUNERAL DIRECTOR

THOMAS FUNERAL HOME CAMBRIDGE MD.

25. DATE RECEIVED BY REGISTRAR  
**JUL 27 1984**25b. REGISTRAR'S SIGNATURE  
**Gina Davidson**



Admitted - 1894

White

1894

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1894

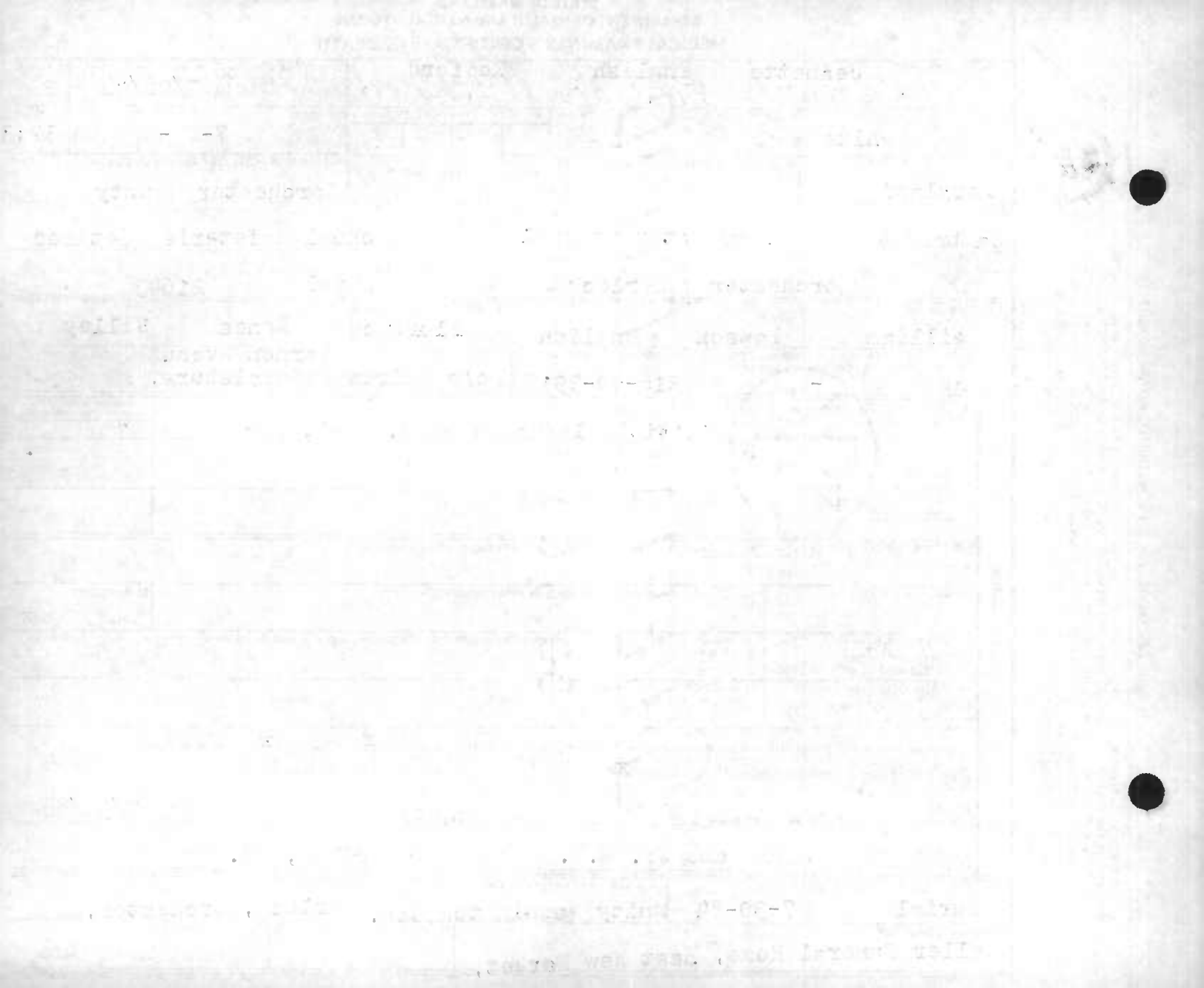
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
30M 7/73

FOR STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2. DATE KNOWN OF DEATH				3. DATE OF DEATH				4. MONTH				5. DAY				6. YEAR				7. HOUR			
Jeanette English Medford				7-26-84				7-27-84				19				12:30				P							
8. SEX		9. RACE		10. DATE OF BIRTH		11. AGE (IN YEARS)		12. IF UNDER 1 YR.		13. IF UNDER 24 HRS.		14. DATE PRONOUNCED DEAD		15. MONTH		16. DAY		17. YEAR		18. HOUR							
F		White		6/6/16		48 YRS.						7-27-		19		84		12:30		A							
19. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				20. CITIZEN OF WHAT COUNTRY?				21. MARRIED				22. NEVER MARRIED				23. BALTIMORE CITY OR COUNTY OF DEATH				24. MD							
Maryland				USA				WIDOWED				DIVORCED				Dorchester County											
25. CITY OR TOWN OF DEATH				26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				27. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				28. KIND OF BUSINESS OR INDUSTRY				29. Retired											
Cambridge				Dorchester General				School Cafeteria																			
30. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				31. STATE				32. COUNTY				33. CITY OR TOWN				34. INSIDE CITY LIMITS?				35. STREET ADDRESS							
				MD				Dorchester				Hurlock				YES				NO							
36. FATHER'S NAME				37. MOTHER'S MAIDEN NAME				38. WAS DECEASED EVER IN U.S. ARMED FORCES?				39. SOCIAL SECURITY NO.				40. INFORMANT				41. ADDRESS							
William Lawson English				Florence Agnes Willey				No				216-40-3918				Lois Andrew				Federalburg, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) Multiple injuries head, neck, face												?															
9289																											
DUE TO, OR AS A CONSEQUENCE OF																											
(b)																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?															
												YES				NO											
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
UNDERLYING				HOUR A.M. MONTH DAY YEAR																							
CONTRIBUTING				P.M. 19																							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																			
WHILE AT WORK								STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
23a. ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED																			
John Mace Jr. M.D.				Deputy				7/31/84																			
23b. EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION															
John Mace Jr. M.D.				Cambridge, Md.				Unity Washington Cem.				Hurlock, Dorchester, MD															
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
Zeller Funeral Home, East New Market, MD				AUG 13 1984				Julia Davidson-Rendell																			

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 3 9 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise T Melvin			2a. DATE OF DEATH MONTH DAY YEAR 07 18 84			2b. HOUR 1 55 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 16 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 114 High Street 21613		
14. FATHER'S NAME FIRST MIDDLE LAST HOUSTON TODD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Gordy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 220 263 242	
17. INFORMANT ADDRESS DORIS MATTHEWS 209 OAKLEY ST.			17. INFORMANT ADDRESS CAMBRIDGE MD.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) EMPYEMA OF GALL BLADDER

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DAYS

DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

PULMONARY EMBOLUS, INCARCERATED HIATAL HERNIA

19a. DATE OF OPERATION 6/19/84 7/9/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INCARCERATED HIATAL HERNIA EMPYEMA OF GALL BLADDER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/18 1984, to 7/18 1984, that (I) (we) lost saw the deceased alive on 7/18 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David B. Stoeckle MD		DEGREE		22c. DATE SIGNED 7/18/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE M.D.		22e. ADDRESS 400 AURORA ST. CAMBRIDGE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-20-84		23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR MD.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JUL 24 1984		25b. REGISTRAR'S SIGNATURE Julian Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 3 9 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM REGINALD MILLS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>07 19 84</b>		2b. HOUR <b>2 35 PM</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>07 20 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter-self employed</b>	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Mills</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Elliott</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>Yes WW2</b>		16b. SOCIAL SECURITY NO. <b>217108334</b>		17. INFORMANT ADDRESS <b>Catherine G. Mills Item # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 16</b> , 19 <b>84</b> , to <b>July 18</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>July 17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edmund J. MacLaykin</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/19/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edmund J. MacLaykin</b>		22e. ADDRESS <b>10 Aurora St. Cambridge, Md 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>7/22/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Thomas Funeral Home</b>		ADDRESS <b>Cambridge Md.</b>		25. DATE REC'D. BY REGISTRAR <b>JUL 27 1984</b>	26. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>

MEDICAL CERTIFICATION

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19394							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISAAC LAKE NICHOLS, JR.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 7-19-84		2b. HOUR PM PM					
3. SEX male		4. RACE cau.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1912		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 71		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR July 19, 84		2d. HOUR PM PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH CAMBRIDGE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farming				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland										13b. COUNTY Dorchester		13c. CITY OR TOWN Linkwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD 2, Chateau Rd., Box 337 Cambridge, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC LAKE NICHOLS,										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LIDA SCHUYLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO										16b. SOCIAL SECURITY NO. 214-07-8520		17. INFORMANT (NAME AND ADDRESS) Lydia Westbrook Nichols, Linkwood,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few. Mins							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>John Mace Jr.</u> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 7/20/84							
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D. ADDRESS Cambridge, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 7/22/84		23c. NAME OF CEMETERY OR CREMATORY East New Market CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE East New Market, Dor. Co., Md.							
24. FUNERAL DIRECTOR CURRAN FUNERAL HOME, 308 High St., Cambridge, Md.										25a. DATE REC'D. BY REGISTRAR JUL 23 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					



100 E S JUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 4 1 9 3 9 5		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST LAST		7a. DATE OF DEATH		MONTH DAY YEAR	
Anthony STANISLAUS		Niewinski		7/15/84		1 30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		CAUC.		11 17 81		72 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Penn.		USA				DORCHESTER MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		THE CAMBRIDGE HOUSE N.H.		SELF EMP. FLOOR CONTRACTOR			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		KENT		GALENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Anthony NMN		Mary Stefanski		NO		186-09-9556	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
ALICE THORNE		daughter		same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Sepsis		(b) Polycythemia Vera			
		(c) ASCVD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		S/P CVA, organic Brain Syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Michael Fadden M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS			
MICHAEL FADDEN		TANMAN		CAMBRIDGE HOUSE, CAMBRIDGE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		7-19-1984		St. Peter & Paul		Springfield Del. Pa.	
24. FUNERAL DIRECTOR		24b. NAME		24c. ADDRESS		24d. DATE REC'D. BY REGISTRAR	
Edward Fellows & Son		Millington, Md.				JUL 20 1984	
24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE		24g. REGISTRAR'S SIGNATURE		24h. REGISTRAR'S SIGNATURE	

BP

CLASSIFICATION

GROUP

REMARKS

DATE

TIME

1. NAME OF SUBJECT

2. ADDRESS

3. DATE OF BIRTH

4. SEX

5. RACE

6. OCCUPATION

7. EDUCATION

8. SOCIAL SECURITY NUMBER

9. MARITAL STATUS

10. RELIGION

11. POLITICAL AFFILIATION

12. CURRENT EMPLOYER

13. SOURCE

14. METHOD

15. DATE

16. INITIALS

17. SIGNATURE

18. OFFICIAL TITLE

19. ORGANIZATION

20. DATE OF INTERVIEW

21. INTERVIEWER

22. REVIEWER

23. DATE OF REVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 4 1 9 3 9 6									
1- FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) George H. Oblinger						2a. DATE OF DEATH MONTH DAY YEAR 7 17 84		2b. HOUR 6:15 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 08 22 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction		12b. KIND OF BUSINESS OR INDUSTRY engineer	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 Richardson Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Oblinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Felicia Botkin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No				16b. SOCIAL SECURITY NO. 265-05-5935		17. INFORMANT ADDRESS Richard J. Oblinger 2301 Cummings Flint Mich.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA. DUE TO, OR AS A CONSEQUENCE OF (b) Recent U.T.I. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/16 19 84 to 7/17 19 84, that (I) (we) last saw the deceased alive on 7/16 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Vinodrai Mehta						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINODRAI MEHTA						22e. ADDRESS 440 AURORA St Cambridge Md 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 7/18/84		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory Lewes		23d. LOCATION CITY OR TOWN COUNTY STATE Sussex Del.		
24. FUNERAL DIRECTOR NAME J. C. T. Brown 700 Secret St. Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR JUL 24 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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Director

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Construction on land

Construction on land

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U.S. Department of Agriculture

Washington, D.C.

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U.S. Department of Agriculture

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 3 9 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST <i>Virginia Leigh PARELLA</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>07 28 84</i>	
3. SEX <i>Female</i>		2b. HOUR <i>3 52 PM</i>	
4. RACE <i>CAU.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MAY 18, 1917</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>DORCHESTER</i>		10. CITY OR TOWN OF DEATH <i>CAMBRIDGE</i>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DORCHESTER GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MANAGER/OWNER</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>FAST FOOD</i>		13a. STREET ADDRESS / ZIP CODE <i>409 ATLANTIC AVE. 21613</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>SAMUEL MOORE</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SADIE E. COX</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-16-8506</i>	
17. INFORMANT <i>Husband</i>		ADDRESS <i>Darcy Parella, same as 13e</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-11</i> , 19 <i>84</i> , to <i>7-28</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>7-28</i> , 19 <i>84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated observe (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <i>E. MacLaughlin</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <i>7/28/84</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edmund J. MacLaughlin</i>	
22e. ADDRESS <i>10 Aurora St, Cambridge, Md 21613</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>	
23b. DATE <i>7/31/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Mem. pt.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Airey, Cambridge, Dorchester, Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>Curran Funeral Home 308 High St., Cambridge, Md. 21613</i>	
25a. DATE REC'D. BY REGISTRAR <i>JUL 31 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rodell</i>	



61-107-272

WATKINS, LEO  
FARLEY

MAY 18, 1955

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 9 3 9 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Isabel S. Shorter Paysinger</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>7 31 84</i>				2b. HOUR M <i>11:35</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>CAU.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>DEC. 7, 1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i>		IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		IF UNDER 24 HRS HOURS MIN. <i>YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>DORCHESTER</i> MD.					
10. CITY OR TOWN OF DEATH <i>CAMBRIDGE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DORCHESTER GENERAL HOSP.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Maple Dam Rd., Rt. 1, Box 63</i>	
14. FATHER'S NAME <i>SOLOMAN RICHARDSON SHORTER</i>				15. MOTHER'S MAIDEN NAME <i>OCTAVIA ELLEN LAWSON</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-05-4413</i>		17. INFORMANT <i>D Ronald Edgar, Maple Dam Rd., Cambridge</i>				ADDRESS <i>Md., 21613</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/30/84</i> , 19 <i>84</i> , to <i>7/3/84</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>7/3/84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Lawrence Maryann M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>7/3/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Maryann, MD</i>				22e. ADDRESS <i>610 Race St Cambridge, Md 21613</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>8/2/84</i>		23c. NAME OF CEMETERY <i>East New Market</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>East New Market, Dor., Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Curran Funeral Home</i>				ADDRESS <i>308 High St. Cambridge Md</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 6 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

BP



1918

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 9 3 9 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FRANCIS WILLARD RICHARDSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 13 84</b>				2b. HOUR <b>9:45 AM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 31 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>mariner-retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>103 Choptank Terrace 21613</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Richrdson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Lee Airey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 1</b>		17. INFORMANT <b>Sarah L. Richardson</b>		ADDRESS <b>Item # 13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ATHEROSCLEROTIC CARDIO VASCULAR DISEASE</b> MONTHS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <b>MALNOURISHMENT</b>											
19a. DATE OF OPERATION <b>6/25/84</b> <b>7/11/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GANGRENE RIGHT FOOT</b> <b>GANGRENE RIGHT STUMP</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6/24</b> 19 <b>84</b> to <b>7/13</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/12</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>David B. Stoeckle</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/13/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID B. STOECKLE M.D.</b>				22e. ADDRESS <b>400 AVENUE F CAMBRIDGE MD 21613</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>7/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Churchyard</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Church Creek Dor. Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 9 1 0 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Mary E. Showell		7 21 84				0203 <sup>h</sup> m	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female	Black	8 9 04		79		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Eastern Shore Hospital Center		Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Caroline		Henderson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
XXXX John		XXXX Clara		No		220-03-6207	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Gertrude Johnson Henderson, MD		PART I. DEATH WAS CAUSED BY:		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Statistical Data Sheet patient chart		(a) Heat failure (acute)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		(b) <del>stroke</del> ASCVD & Heart Failure (chronic)					
		(c)					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR				WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>	
		P.M. 19				AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
22a. I certify that (I) this hospital attended the deceased from 6/12/84, 19 84, to July 21, 19 84, that (I) (we) last saw the deceased alive on 7/21/19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		William Craig Wessells, M.D.		7/21/84		William Craig Wessells	
		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS	
						6501 N. Charles St. Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7-24-84		Union Cemetery		Goldsboro CA MD	
24. FUNERAL DIRECTOR		25. DECEASED		26. REGISTRAR		27. REGISTRAR	
John E. Boulden		JUL 24 1984		John E. Boulden		John E. Boulden	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8419401

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Maude M. Simmons</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 14 1984</i>		2b. HOUR <i>9:30 AM</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 3 1884</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>100</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>DORCHESTER</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Glasgow Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher/housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>		13b. COUNTY <i>Dorchester</i>	13c. CITY OR TOWN <i>Cambridge</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>312 Belvedere 21613</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Mills</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mahalia Edgar</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>220-44-9489</i>		17. INFORMANT <i>Glasgow Nsg. Home</i>		ADDRESS <i>311 Glenburn Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MULTIPLE CVA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ATHEROSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i> <i>Years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>CHF, EXTREME AGE, ATRIAL FIB.</i>					
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/2/81</i> to <i>7/14/84</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>7/13/84</i> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <i>Hubert L. Fierly</i>		DEGREE		22c. DATE SIGNED <i>7/14/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUBERT L. FIERLY MD</i>		22e. ADDRESS <i>503 BYRN STREET, CAMB, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>7/17/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Dor. Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cambridge Dor. Md.</i>
24. FUNERAL DIRECTOR NAME <i>Robert J. Jones</i>		ADDRESS <i>700 South St. Cambridge, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 23 1984</i>	
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Douglas Strand			2a. DATE KNOWN OF DEATH 7-12 1984			2b. HOUR AM		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 3-9-1900	6. AGE (IN YEARS) 84 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD July 12 1984		2d. HOUR 9:20
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 519 Cedar St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21613 519 Cedar St.			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Strand			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Mae White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-07-8757		17. INFORMANT Thelma Hollis Cambridge, Md. 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>			TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 7/13/84		
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.			ADDRESS Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/14/84		23c. NAME OF CEMETERY OR CREMATORY Bethel AME Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor.. Md.	
24. FUNERAL DIRECTOR NAME Lewis H. Boardley ADDRESS Cambridge, Md.								

21613 JUL 16 1984 REGISTRAR'S SIGNATURE  
*Julia Davidson-Randall*



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JAN 10 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8419403

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hamlet L. Ward			2a. DATE OF DEATH MONTH DAY YEAR 7 25 84			2b. HOUR 8 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 22 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester R. MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman	
12b. KIND OF BUSINESS OR INDUSTRY retail							
13a. USUAL RESIDENCE 13a. STATE MD		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 402 Linden Ave 21613							
14. FATHER'S NAME FIRST MIDDLE LAST James Ward				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tabitha Gladden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-40-8440		17. INFORMANT ADDRESS Grace Ward Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe arteriosclerosis, aneurysm, CHD.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 12 hrs. 15 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION 7.24.84.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe peripheral vasc. dis.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A.			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from 7.24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE A.R. Wink		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7.25.84.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.R. Wink		22e. ADDRESS 400 Maryland Ave. Cambridge					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/27/84		23c. NAME OF CEMETERY OR CREMATORY RED BANK BAPTIST CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge MD 21613	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR AUG 01, 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME(5))  
15M 2/80

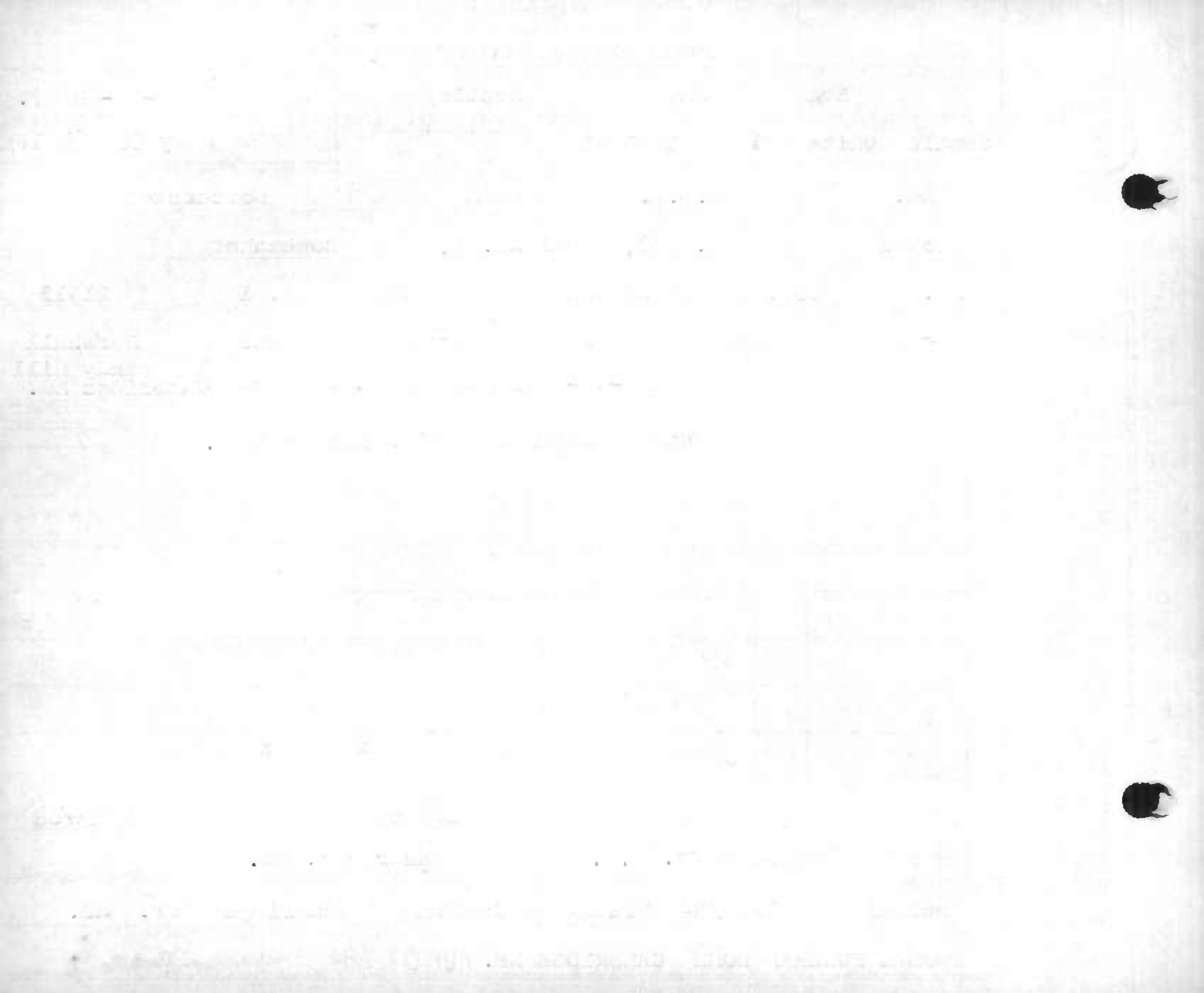
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva May Wheatley		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7-22-84		2b. HOUR P. M.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 03 22 1891	6. AGE (IN YEARS) LAST BIRTHDAY 93 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Lloyds		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 343, Rural Rt. 1,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker
13a. STATE Md.		13b. COUNTY Dor.	13c. CITY OR TOWN Lloyds	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Levin James Seward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jane Marshall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-74-8275		17. INFORMANT ADDRESS Mildred W. Jarrett 101 Sandy Hill Cambridge Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Carcinomatosis, cancer face.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>John Mace Jr.</i>		TITLE (SPECIFY) Deputy		DATE SIGNED 7/25/84
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.		ADDRESS Cambridge, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 7/24/84	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

AUG 01, 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8419405	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE F. WONGUS.		2a. DATE OF DEATH MONTH DAY YEAR 7 21 84	
3. SEX m		4. RACE Black.		5. DATE OF BIRTH MONTH DAY YEAR 07 04 18		
6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7b. CITIZEN OF WHAT COUNTRY? USA		7a. HOUR 6 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DORCH. MD		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		
10. CITY OR TOWN OF DEATH CAMBRIDGE.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		
12b. KIND OF BUSINESS OR INDUSTRY -		13a. STATE MD		13b. COUNTY DOR.		
13c. CITY OR TOWN RHODESDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 44 21659		
14. FATHER'S NAME FIRST MIDDLE LAST WILL WONGUS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BOWYKPP Isabelle Bowens TANNIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No UNKNOWN		
16b. SOCIAL SECURITY NO. 217-12-4465		17. INFORMANT Tanzie Wongus, Box 44, Rhodesdale, Md. 21659		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular tachycardia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 7:15 19 84 to 7:21 19 84, that (I) (we) last saw the deceased alive on 7:21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE AR Wince		
22c. DATE SIGNED 7.21.84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) AR Wince		22e. ADDRESS 400 Marlboro Ave. Cambridge MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 25, 1984		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Rhodesdale, Dorchester, Md.		24. FUNERAL DIRECTOR NAME FRAMPTON-HAWKINS		25a. DATE REGD. BY REGISTRAR JUL 24 1984		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

Roberts, Dorchester, Inc.